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| |  | | --- | | **Physical Exam Report** |      |  |  |  | | --- | --- | --- | | <date> | <animal> | | | <last-name> | <breed> | | | <phone> | <species> | <age> | |  | <sex> | <color> | |  |  |  | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Presenting Complaint** | | | | | | | **Vaccination Program Given** | | | **Urogenital** | | | |  Rabies |  DHLPP |  Bordetella |  Appears Normal |  Abnormal Testicles |  Abnormal Mammary | |  FVRCP |  Leukemia |  Dewormed |  Other |  |  | |  |  |  |  |  |  | | **Hair Coat & Skin** | | | **Cardiovascular** | | | |  Appear Normal |  Fleas/Ticks |  Hair Loss |  Sounds Normal |  Slow |  Fast | |  Wounds |  Dry & Scaly |  Itchy |  Murmur |  Arrhythmia |  Other | |  Matted |  Shedding |  Oily |  |  |  | |  Tumor(s) |  Dull |  Other |  |  |  | | **General Appearance** | | | **Lungs** | | | |  Appears Normal |  Overweight |  Underweight |  Sound Normal |  Congestion |  Rapid Respiration | |  Enlarged Lymph Nodes |  Lethargic |  Poor Appearance |  Coughing |  Breathing Difficulty |  Wheezing | |  Other |  |  |  Other |  |  | | **Eyes** | | | **Musculoskeletal** | | | |  Appear Normal |  Conjunctivitis |  Corneal Ulcer |  Appears Normal |  Stiff |  Limping | |  Discharge |  Infection |  Cataract L/R/B |  Muscle Atrophy |  Painful |  | |  Corneal Pigmentation |  Inflamed |  Tumor |  |  |  | |  Other |  |  |  |  |  | | **Ears** | | | **Neurological** | | | |  Appear Normal |  Inflamed |  Foul Odor |  Appears Normal |  Postural Deficits |  Seizures | |  Painful |  Yeast/Bacteria |  Itchy |  Paresis/Paralysis |  Mentation Change |  Head Tilt | |  Mites |  Tumor |  Other |  |  |  | | **Nose & Throat** | | | **Abdomen** | | | |  Appear Normal |  Sneezing |  Inflamed Tonsils |  Normal |  Abnormal Mass |  Painful/Tense | |  Nasal Discharge |  Tumor |  Pigment Change |  Distended |  Constipated |  Other | |  |  |  |  |  |  | | **Mouth, Teeth & Gums** | | | **Gastrointestinal** | | | |  Appear Normal |  Receded Gums |  Broken/Loose Teeth |  Appears Normal |  Vomiting |  Diarrhea | |  Ulcers |  Tumors |  Gingivitis |  Soft Stool |  Hard Stool |  Not Eating | |  Tartar Mild |  Tartar Moderate |  Tartar Severe |  Excessive Gas |  Anal Glands Full |  Other | |  Periodontal Disease |  Other | |  |  |  | | | | |

**CONSENT for ADMISSION and TREATMENT**

|  |  |  |
| --- | --- | --- |
| <date> | <animal> | <breed> |
| <client> | <age> | <color> |
| <phone> | <cell-phone> | <species> |

Treatment(s) or Procedure(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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As the owner of <animal>, I certify that I am over the age of 18. I understand that medicine is an inexact science, and in the event my pet requires anesthesia, surgery, medications, immunizations, and/or other treatments, I accept that there are risks involved with such care. I hereby authorize the doctor(s) and staff at Council Veterinary Hospital to prescribe medications for, perform treatments on, pursue life saving emergency procedures for, and as agreed upon, sedate or anesthetize and perform surgery or other procedures on my pet.

I understand that payment is due at the time of services rendered, and I agree to pay all costs associated with collection of unpaid services.

I understand that, with exception of emergency/life-saving efforts, the staff at this practice will provide me with an estimate of charges prior to the performance of these procedures. I agree to pay all charges associated with these treatments. I accept that full payment for services and products is expected at the time my pet is ready to be discharged from this facility. If my pet is not current on the vaccinations, fecal testing, and deworming, I accept that they may be administered during my pet’s stay and I will assume financial responsibility for them.

I agree to maintain communication with the staff at this practice during my pet’s stay and will check on the status of my pet’s condition and the associated fees no less than every 24 hours. I agree to pickup my pet or have an authorized agent do so within 24 hours of the date the doctor(s) or staff notifies me that he/she is ready for discharge. If I cannot or do not fulfill the agreements set forth in this consent form within 3 days of my pet being release, I accept that my pet will be considered abandoned and transfer of ownership will be given to Council Veterinary Hospital.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Owner or Agent Date



CVH Examination Form

<animal> <client> <weight> <age> <sex> <date>

Temp: \_\_\_\_\_\_\_\_\_ Heart Rate: \_\_\_\_\_\_\_\_\_ Respiration: \_\_\_\_\_\_\_\_\_ CRT: \_\_\_\_\_\_\_\_\_ URINE\_\_\_\_\_\_\_\_\_

Gum Color (other):\_\_\_\_\_\_ EHR: \_\_\_\_\_\_\_\_ HWT: \_\_\_\_\_\_\_\_\_ FCombo: \_\_\_\_\_\_\_\_\_ FECAL:\_\_\_\_\_\_\_\_\_

SUBJECTIVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Nose/Throat: \_\_\_\_\_ Oral: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_ Cardiovascular: \_\_\_\_\_

Respiratory: \_\_\_\_\_\_ Abdominal: \_\_\_\_\_\_ Coat/Skin: \_\_\_\_\_\_ Urogenital: \_\_\_\_\_\_ Rectal: \_\_\_\_\_\_

Musculoskeletal: \_\_\_\_\_\_ Extremities: \_\_\_\_\_\_ Neurologic/Gait: \_\_\_\_\_\_

ASSESSMENT (Diagnosis/Rule Out): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLAN:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_